Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MILLENNIUM CHIROPRACTIC

Respondent Name
AMERICAN HOME ASSURANCE CO

MFDR Tracking Number
M4-14-1246-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JANUARY 3, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "THESE TESTS ARE REQUIRED BY THE ODG WHILE THE PATIENT PARTICIPATES IN A CPM PROGRAM—AND MUST BE PAID IN FULL. THE PATIENT IS ALSO REQUIRED TO DO AN 'EXIT' ASSESSMENT/FCE ONCE SHE COMPLETES THE PROGRAM—AND THIS SHOULD BE PAID IN FULL AS WELL AS IT IS MANDATED PER ODG."

Amount in Dispute: $779.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 11, 2013	CPT Code 97750-FC (16 units) Functional Capacity Evaluation (FCE)	$779.20	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §137.100, effective January 18, 2007, sets out the use of the treatment guidelines.
3. 28 Texas Administrative Code §134.204 and §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 45-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
   - M359-Time expended on or the number of Functional Capacity Evaluations has been exceeded.
   - Z656-Any request for reconsideration of this workers' compensation payment should be accompanied by a copy of this explanation of review.

5. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on January 13, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Issues

1. Is the requestor exempt from the FCE limits outlined in 28 Texas Administrative Code §134.204(g)?
2. Is the requestor entitled to reimbursement for the functional capacity evaluation rendered on January 11, 2013?

Findings

1. Based upon the submitted explanation of benefits, the respondent denied reimbursement for code 97750-FC based upon reason code "M359."

   On the disputed date of service, the requestor billed CPT code 97750-FC.

   The American Medical Association (AMA) Current Procedural Terminology (CPT) defines CPT code 97750 as "Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes."

   The requestor appended modifier "FC" to code 97750. 28 Texas Administrative Code §134.204(n)(3) states, "The following Division Modifiers shall be used by HCPs billing professional medical services for correct coding, reporting, billing, and reimbursement of the procedure codes. (3) FC, Functional Capacity-This modifier shall be added to CPT Code 97750 when a functional capacity evaluation is performed."

   28 Texas Administrative Code §134.204(g) states,"The following applies to Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the Division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required."

   The requestor states in the position summary that "**THESE TESTS ARE REQUIRED BY THE ODG WHILE THE PATIENT PARTICIPATES IN A CPM PROGRAM—AND MUST BE PAID IN FULL. THE PATIENT IS ALSO REQUIRED TO DO AN 'EXIT' ASSESSMENT/FCE ONCE SHE COMPLETES THE PROGRAM—AND THIS SHOULD BE PAID IN FULL AS WELL AS IT IS MANDATED PER ODG**."

   The ODG guidelines that the requestor refers to in the position are addressed in 28 Texas Administrative Code §137.100. Review of the documentation submitted finds that the requestor failed to provide the portions of the ODG that related to FCEs and chronic pain management to support its assertion that the service in dispute would be "required" by the ODG. The Division concludes that the requestor's assertion regarding alleged requirement for FCEs is not supported. In addition, the requestor has not shown compliance with any applicable requirements in 28 Texas Administrative Code §137.100(f). For these reasons, 28 Texas Administrative Code §134.204(g) applies to the disputed service.

2. The requestor states, "The first three FCEs were used to document the necessity for the patient to be admitted into the Chronic Pain Management programs…this final FCE performed on 01/11/13 is required…to determine a return to work capacity." By the requestor's own admission, the FCE in dispute is the fourth for the injury. The Division finds that the requestor exceeded the maximum of three FCEs for each compensable injury that may be billed and reimbursed pursuant to 28 Texas Administrative Code §134.204(g). As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

		12/04/2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

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